TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain & Recovery Clinic - North

Respondent Name
Commerce & Industry Insurance Company

MFDR Tracking Number
M4-16-3395-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the fee schedule guidelines. We are a CARF accredited facility and should not be subject to the twenty percent fee schedule reduction."

Amount in Dispute: $2125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Chronic Pain Management Daily Activity Sheets show and the carrier reimbursed:

04/04/16 1.5 hours @ $125.00 =	$187.50
04/08/16 2.0 hours @ $125.00+	$250.00
04/11/16 2.0 hours @ $125.00	$250.00
04/12/16 2.0 hours @ $125.00	$250.00
Total	$812.50

The carrier reimbursed based on the treatment notes. The Carrier did not reimburse for the claimant eating lunch with other patients or for playing games with other patients which the Pain & Recovery Clinic submitted with the documentation for medical dispute resolution."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4 – 12, 2016	Chronic Pain Management	$2125.00	$2000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Workers' compensation jurisdictional fee schedule adjustment.
   - The charge for the procedure exceeds the amount indicated in the fee schedule.

Issues

1. What is the total allowable reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(h) states:

   The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. **To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual** [emphasis added], which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

   (5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

   The requestor is seeking reimbursement for 5.5 hours for date of service April 4, 2016. Submitted documentation supports 5.25 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a maximum allowable reimbursement (MAR) of $656.25.

   The requestor is seeking reimbursement for 6 hours for date of service April 8, 2016. Submitted documentation supports 5.75 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $718.75.

   The requestor is seeking reimbursement for 6 hours for date of service April 11, 2016. Submitted documentation supports 5.75 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $718.75.

   The requestor is seeking reimbursement for 6 hours for date of service April 12, 2016. Submitted documentation supports 5.75 hours of the disputed services performed. The documented time multiplied by $125 per hour provides a MAR of $718.75.

2. The total allowable amount for the disputed services is $2812.50. The insurance carrier paid $812.50. An additional reimbursement of $2000.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2000.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2000.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	October 7, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.